

AOTA ANALYSIS: CY 2013 PHYSICIAN FEE SCHEDULE PROPOSED RULE

The Centers for Medicare & Medicaid Services (CMS) has released the CY 2013 Medicare Physician Fee Schedule Proposed Rule: “[Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013.](#)” (77 *Federal Register* 44722 [July 30, 2012]). The proposed rule contains 341 pages and includes changes that would affect occupational therapy practitioners and students. Comments are due to CMS on September 4, 2012.

Overview

Notably for the occupational therapy profession, the proposed rule reiterates the multiple procedure payment reduction (MPPR) policy for therapy, lays out a plan to collect data on patient function to inform how Medicare pays for outpatient therapy services, proposes to implement a durable medical equipment face-to-face requirement as a condition of payment for certain high-cost items, and modifies reportable measures under the Physician Quality Reporting System (PQRS).

Background

Since 1992, CMS has paid for the services of physicians, suppliers, and non-physician practitioners—such as occupational therapy practitioners—under the Medicare Physician Fee Schedule (MPFS or fee schedule), the system that determines payment amounts for covered Medicare Part B services. Under the MPFS, a relative value is assigned to each of more than 7,000 types of services to capture the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice expenses typically involved in furnishing the service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment. The RVUs for a particular service are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor (both of which change annually) to determine the payment amount for each service.

I. OUTPATIENT THERAPY SERVICES

A. Claims-Based Functional Data Collection

The Middle Class Tax Relief and Jobs Creation Act of 2012, which included a temporary sustainable growth rate (SGR) fix for fee schedule payments and an extension of the therapy cap exceptions process through the end of 2012, required CMS to gather data about patient function and condition on claims forms beginning in 2013:

a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the [Social Security] Act. Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.

Source: The Middle Class Tax Relief and Jobs Creation Act § 3005(g).

To implement this statutory mandate, CMS says it looked to outpatient therapy utilization analyses prepared in recent years (as required by the Balanced Budget Act of 1997), the Short Term Alternatives for Therapy Services (STATS) project, comments to the CY 2011 fee schedule proposed rule, and internal research efforts. Based on this information, the agency concluded:

without the ability to define the services that are typically needed to address specific clinical cohorts of beneficiaries (those with similar risk-adjusted conditions), it is not possible to develop payment policies that encourage the delivery of reasonable and necessary services while discouraging the provision of services that do not produce a clinical benefit. Although there is widespread agreement that beneficiary condition and functional limitations are critical to developing and evaluating an alternative payment system for therapy services, a system for collecting such data does not exist. Diagnosis information is available from Medicare claims. However, we believe that the primary diagnosis on the claim is a poor predictor for the type and duration of therapy services required. Much additional work is needed to develop an appropriate system for classifying clinical cohorts.

Source: 77 Fed. Reg. 44722, 44765.

Under the proposal, practitioners furnishing outpatient therapy services will be required to include new, nonpayable G-codes and modifiers on claim forms for therapy services. The codes and modifiers would not affect payment, but would convey information about patients' functional limitations at the outset of therapy, at specified points throughout therapy, and at discharge from the therapy episode of care. Information on the practitioner's projected patient goals will also be collected under this proposal. Proposed frequency of reporting is consistent with existing requirements for therapy progress notes.

A continuum of six G-codes (plus one code indicating that functional reporting is not required) would be used to identify what is being reported: current status, goal status, or discharge status. A scale of 12 modifiers would indicate the extent of the severity/complexity of the functional limitation being tracked. As is the case now, ICD-9 diagnosis codes reported on the claim form would continue to provide information on the beneficiary's condition and complexities.

Proposed Nonpayable G-Codes for Reporting Functional Limitations

Functional limitation for primary functional limitation		
GXXX1	Primary Functional limitation	Current status at initial treatment/episode outset and at reporting intervals
GXXX2	Primary Functional limitation	Projected goal status
GXXX3	Primary Functional limitation	Status at therapy discharge or end of reporting
Functional limitation for a secondary functional limitation if one exists		
GXXX4	Secondary Functional limitation	Current status at initial treatment/outset of therapy and at reporting intervals
GXXX5	Secondary Functional limitation	Projected goal status
GXXX6	Secondary Functional limitation	Status at therapy discharge or end of reporting
Provider attestation that functional reporting not required		
GXXX7		Provider confirms functional reporting not required

Source: Table 17, Fed. Reg. 44766-7. These are in addition to possible “select” categories of G-codes, GXX8-GXX25, derived in part from Developing Outpatient Therapy Payment Alternatives (DOTPA) data (*see:* Table 19, Fed. Reg. 44770).

Proposed Modifiers

Modifier	Impairment Limitation Restriction Difficulty
XA	0%
XB	Between 1-9%
XC	Between 10-19%
XD	Between 20-29%
XE	Between 30-39%
XF	Between 40-49%
XG	Between 50-59%
XH	Between 60-69%
XI	Between 70-79%
XJ	Between 80-89%
XK	Between 90-99%
XL	100%

Source: Table 18, Fed. Reg. 44768.

CMS proposes a reporting frequency for G-codes and associated modifiers of once every 10 treatment days or at least once during each 30 calendar days, whichever time period is shorter.

The first treatment day for purposes of reporting would be the day of the initial visit, and the episode of care begins at the evaluation. CMS selected this 10/30 timeframe to be consistent with timing requirements for progress reports. (See: [Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 15, § 220.3\(D\), “Documentation Requirements for Therapy Services”](#)). If, however, a formal and medically necessary re-evaluation of the beneficiary results in an alteration of the goals in the beneficiary’s Plan of Care (due to new clinical findings, an added comorbidity, or a failure to respond to treatment) G-code and modifier measures would be required to be reported, affording the practitioner an opportunity to revise the beneficiary’s severity status and/or explain a beneficiary’s failure to progress.

The practitioners who would be eligible to report these figures on the claim form include occupational therapists, physical therapists, speech- language pathologists, physicians, and certain non-physician practitioners, such as physician assistants, nurse practitioners, and clinical nurse specialists. (Fed. Reg. 44765).

CMS proposes to implement this new system on January 1, 2013, in accordance with the authorizing statute. The first six-months would be a “testing period,” which would allow providers time to make the transition in their reporting systems, and after July 1, 2013 CMS would not process any claims without the required G-codes and modifiers.

CMS intends to use the data collected using these G-codes and modifiers to “reform” the Medicare payment system for outpatient therapy services and institute a new payment system that, among other things, “would not encourage the furnishing of medically unnecessary or excessive services.” (Fed. Reg. 44766). AOTA has serious concerns about this proposal, many of which we outlined in comment letters submitted to CMS during CY 2011 rulemaking. We question the ability of such a system to gather the necessary information and are concerned about the provider outreach and education necessary to responsibly and accurately collect this data in the two months between the release of the final rule and the slated implementation date.

AOTA is researching this proposal and conducting outreach to members and other experts in the field. Please submit your thoughts and comments to AOTA’s Reimbursement and Regulatory Policy Department at rpd@aota.org.

B. Therapy Cap

The therapy cap amount for CY 2012 is \$1,880 for occupational therapy and \$1,880 for physical therapy and speech-language pathology, combined. The cap amount for CY 2013 is not yet known and will be announced by CMS in the fee schedule final rule, expected on or about November 1, 2012.

C. Multiple Procedure Payment Reduction (MPPR)

CMS reiterated the application of a multiple procedure payment reduction (MPPR) policy for outpatient therapy services in the proposed rule, noting that the reduction applies to the practice expense (PE) for second and subsequent therapy services furnished to a single patient in a single day by a single provider and is 25% in institutional settings and 20% in office settings.

CMS also proposed applying a MPPR of 25% to the technical component of certain cardiovascular and ophthalmology diagnostic services.

II. FACE-TO-FACE REQUIREMENT FOR DURABLE MEDICAL EQUIPMENT (DME)

For specified covered items, Medicare payment may be made only where a physician order is communicated to the supplier prior to delivery of the item. (Social Security Act § 1834). Currently, these items include (1) pressure reducing pads, mattress overlays, mattresses, and beds; (2) seatlift mechanisms; (3) transcutaneous electrical nerve stimulation (TENS) units; and (4) power operated vehicles (POVs) and power wheelchairs.

Section 6407(b) of the Affordable Care Act (ACA) added language to the Social Security Act requiring written orders for certain items of durable medical equipment (DME) and orthotics and prosthetics (O&P) as well as a face-to-face encounter between a beneficiary and a physician, physician assistant, nurse practitioner, or clinical nurse specialist. The statute requires that the encounter occur during the six months prior to the written order for each item or during such other reasonable timeframe as specified by the Secretary of Health and Human Services. (Fed. Reg. 44794-800).

To implement this statutory mandate, help combat perceived fraud, and reduce improper payments for DME and O&P, CMS has proposed to finalize regulations requiring a documented face-to-face visit a condition of payment for certain high-cost DME covered items. Although occupational therapy practitioners are not a required part of the proposed face-to-face encounter requirement, they should be aware of the practice and may be familiar with the similar face-to-face requirements already in existence for the Medicare home health and Medicaid DME benefits.

III. PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

The Physician Quality Reporting System (PQRS) establishes a financial incentive for eligible professionals, including occupational therapists in private practice and with an individual-level National Provider Identifier (NPI), to participate in a voluntary quality reporting program. Occupational therapists working in hospitals or skilled nursing facilities (SNFs) whose employers bill for their services through a Fiscal Intermediary (FI) cannot participate in PQRS because these clinicians do not bill for their services through their own NPI. For background information, see [AOTA PQRS CY 2012 Fact Sheet](#), which will be updated pending finalized information from CMS on PQRS CY 2013.

The incentives operate on a calendar year basis, and incentive payments are authorized through 2014 with a penalty thereafter for eligible professionals who do not satisfactorily report. For CY 2013, eligible professionals who satisfactorily report data on PQRS quality measures will earn a 0.5% incentive payment on their total allowed charges during the reporting period.

For CY 2012, occupational therapists were eligible to report on 17 quality measures. CMS is proposing to retire some of these measures (e.g., “Health Information Technology (HIT):

Adoption/Use of Electronic Health Records (EHR)”) and add others—information on the applicability of these proposed additions is forthcoming, pending the availability of CMS’s measure specifications. In addition, CMS is proposing changes to PQRS beginning in CY 2013 to simplify and aid in the readability of PQRS election requirements, both for individuals and group practices, as well as changes to the registry qualification process.

IV. PRIMARY CARE AND CARE COORDINATION

Congress and CMS have been placing increasing emphasis on primary care and care coordination as means to achieve better care for individuals, better health for populations, and reduced costs. In this vein, CMS is proposing to create a new procedure code for community physicians and qualified nonphysician practitioners to account for care coordination necessary for a patient in the 30 days following discharge to the community from an inpatient hospital stay, SNF stay, and certain specified outpatient services. Payment for this proposed new care coordination code need not include a face-to-face encounter. Medicare already pays separately for care management services for individuals with an inpatient admission who are discharged to SNF, home health, or hospice.

Although occupational therapists are not included in the applicable definitions of “community physician” or “qualified nonphysician practitioner” for purposes of this proposed procedure code, AOTA has made the role of occupational therapy in primary care a priority – for more information on our work in this area, see [Metzler, C. A., Hartmann, K. D., & Lowenthal, L. A. \(2012\). Defining primary care: Envisioning the roles of occupational therapy. *American Journal Occupational Therapy*, 66:266–270.](#)

V. TELEHEALTH

The Benefits Improvement Protection Act (BIPA) defined telehealth services and established the categories of providers authorized to furnish such services. (BIPA § 223; Social Security Act § 1834). Because occupational therapists (as well as physical therapists and speech-language pathologists) were excluded from the statutory definition of eligible providers, current Medicare regulations do not cover or reimburse for telehealth services provided by occupational therapists. To include occupational therapists in the definition of eligible providers would require Congress to act and change in the statute. Only physicians and certain non-physician practitioners (such as physician assistants, nurse practitioners, clinical nurse specialists, nurse-midwives, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals) may provide telehealth services, and only when they are appropriately licensed and permitted to do so under state law.

Approved Medicare telehealth services include the following:

- Initial inpatient consultations;
- Follow-up inpatient consultations;
- Office or other outpatient visits;
- Individual psychotherapy;
- Pharmacologic management;

- Psychiatric diagnostic interview examination;
- End-stage renal disease (ESRD) related services;
- Individual and group medical nutrition therapy (MNT);
- Neurobehavioral status exam;
- Individual and group health and behavior assessment and intervention (HBAI);
- Subsequent hospital care;
- Subsequent nursing facility care;
- Individual and group kidney disease education (KDE);
- Individual and group diabetes self-management training (DSMT); and
- Smoking cessation services.

CMS is proposing to add the following services to the list of allowable Medicare telehealth services for CY 2013: alcohol and/or substance abuse assessment and intervention services, annual alcohol misuse screening, brief behavioral counseling for alcohol misuse, annual face-to-face intensive behavioral therapy for cardiovascular disease, annual depression screening, behavioral counseling for obesity, and semi-annual high intensity behavioral counseling to prevent sexually transmitted infections. (Fed. Reg. 44759-63).

Conclusion

AOTA continues to analyze the proposed rule and its implications for occupational therapy. Comments are due on September 4, 2012, and a final rule will be issued by November 1, 2012. AOTA will submit comments to CMS and welcomes your thoughts, particularly regarding plans to collect functional data, at rrpd@aota.org.

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